

Fig. 1

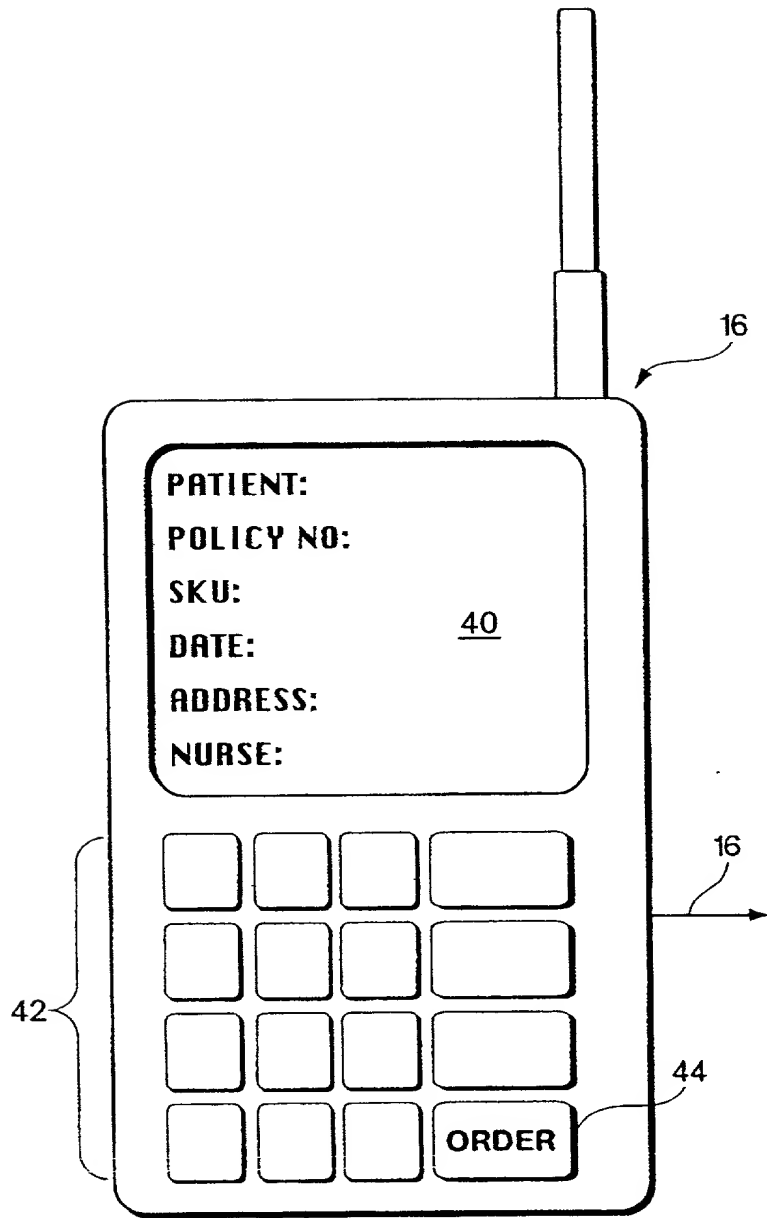


Fig. 2

## Health Insurance Information

### Primary Health Insurance

Insurance Company Name:

Employer Sponsor:

Insurance Address:

Mailing:

City:

State:

Zip:

Subscriber relationship to patient: ☐Self ☐Spouse ☐Parent ☐Other

Subscriber Name:

Certification ID #:

Policy Group or Plan #:

### Secondary Health Insurance

Insurance Company Name:

Employer Sponsor:

Insurance Address:

Mailing:

City:

State:

Zip:

Subscriber relationship to patient: ☐Self ☐Spouse ☐Parent ☐Other

Subscriber Name:

Certification ID#:

Policy Group or Plan #:

Fig. 3

## **Insurance Authorization and Assignment of Benefits**

**Please Read:**

**All charges are due at the time of service. If hospitalization is indicated, the patient is responsible for furnishing insurance claim forms to the office prior to hospitalization .**

**All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage. It is also customary to pay for services when rendered unless other arrangement have been made in advance Witty our office.**

**I hereby authorize and direct payment to \_\_\_\_\_  
of all medical/surgical benefits due on any unpaid bills for services  
provided to me by this physician.**

**I also authorize release of any information necessary for processing of  
this or a related claim.**

**Signature: \_\_\_\_\_  
Date: \_\_\_\_\_**

### **Medicare Patients Only**

**I request that payment of authorized Medicare benefits be made either  
to me or on my behalf to \_\_\_\_\_  
for any services provided to me by that physician.**

**I authorize any holder of medical information about me to release to  
the Health Care Financing Administration and its agents any  
information needed to determine these benefits payable for related  
services. I hereby authorize Medicare to furnish to the above named  
practice any information regarding my Medicare claims under title  
XVIII of the Social Security Act.**

**Signature: \_\_\_\_\_  
Date: \_\_\_\_\_**

**Fig. 4**

## New Patient Information Form

Physician:

Date:

Referring Physician:

Patient Complaint or Diagnosis:

### Patient Information

Name:

Age:

Date of Birth:

SS#:

Sex: ☐ Male ☐ Female

Marital Status:

### Home Address

Street:

City:

State:

Zip:

### Mailing Address

Street:

City:

State:

Zip:

Home Phone:

Business Phone:

Employer:

Name:

Address:

Responsible Party: ☐ Self or

Relationship

Name:

Phone:

Street:

City:

State:

Zip:

### For Emergency Contact Nearest Relative or Friend

Relationship

Name:

Phone:

Street:

City:

State:

Zip:

Healthcare Proxy: ☐ Yes ☐ No

Fig. 5

## Health History Questionnaire

Please help us assess your healthcare needs by taking a few moments to fill out this questionnaire. Some questions may not apply to you, but we ask the same questions of everyone. If you prefer to discuss any particular question in person circle it or leave the answer blank.

All answers are confidential.

Name:

Today's Date:

Age:

Marital Status:

Sex: ☐ Male ☐ Female

Referring MD:

Present Health Concern or Complaint:

### Symptoms

- |                                       |  |                                   |
|---------------------------------------|--|-----------------------------------|
| <input type="radio"/> Frequency       | <input type="radio"/> Hesitancy                        | <input type="radio"/> Fever       |
| <input type="radio"/> Nocturia        | <input type="radio"/> Urgency                          | <input type="radio"/> Chills      |
| <input type="radio"/> Intermittency   | <input type="radio"/> Urge Incontinence                | <input type="radio"/> Prostatitis |
| <input type="radio"/> Hematuria       | <input type="radio"/> Stress Incontinence              | <input type="radio"/> Dribbling   |
| <input type="radio"/> Strain to void  | <input type="radio"/> Dysuria                          | <input type="radio"/> Stones      |
| <input type="radio"/> Force of stream | <input type="radio"/> Sensation of incomplete emptying |                                   |
| <input type="radio"/> UTI             | <input type="radio"/> Pain                             |                                   |

Fig. 6

### Past Urological History

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### Sexual History:

Do you have concerns about your sexual function?

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Other:

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### Past Medical History:

Please list all past and present medical conditions, hospitalizations, surgeries, illnesses or injuries.

Illness/Surgery/Injury/Condition	Where Treated	Physician	Date
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

In particular have you had any of the following?

- |   |   |   |
|---|---|---|
| <input type="radio"/> High Blood Pressure | <input type="radio"/> Stroke                | <input type="radio"/> Kidney Stones       |
| <input type="radio"/> Heart Disease       | <input type="radio"/> Ulcer                 | <input type="radio"/> Thyroid Disorder    |
| <input type="radio"/> Back Problems       | <input type="radio"/> Glaucoma              | <input type="radio"/> Tuberculosis        |
| <input type="radio"/> Anemia              | <input type="radio"/> Seizures              | <input type="radio"/> Gout                |
| <input type="radio"/> Asthma              | <input type="radio"/> Jaundice              | <input type="radio"/> Arthritis           |
| <input type="radio"/> Cancer              | <input type="radio"/> Lung Problems         | <input type="radio"/> Hemorrhoids         |
| <input type="radio"/> Phebitis            | <input type="radio"/> Bleeding Problems     | <input type="radio"/> Bladder Infection   |
| <input type="radio"/> Rheumatic Fever     | <input type="radio"/> Gall Bladder Problems | <input type="radio"/> Intestinal Problems |
| <input type="radio"/> Rectal Bleeding     | <input type="radio"/> Prostate Problems     | <input type="radio"/> Diabetes            |
| <input type="radio"/> Edema               |   |   |

Do you have difficulties with:

- |  |   |  |
|--|---|--|
| <input type="radio"/> Kidney Stones              | <input type="radio"/> Blood in Urine              | <input type="radio"/> Leaking/Losing Urine |
| <input type="radio"/> Painful Burning Urination  | <input type="radio"/> Bladder Infection           |  |
| <input type="radio"/> Kidney Infection           | <input type="radio"/> Starting/Stopping Urination |  |
| <input type="radio"/> Frequent Urgent            | <input type="radio"/> Urinate During the Night    |  |
| <input type="radio"/> Swelling/Pain in Testicles | <input type="radio"/> Bed wetting                 |  |

Fig. 7

**List Current Medications**

(include vitamins and other over the counter medications):

**Medications(Current)**

**Dose and Frequency**


**Allergic Reactions to Any Food or Medications:**

**Food or Medication**

**Reaction**


**Smoking/Alcohol History:**

Do you, or have you ever smoked cigarettes, cigars or pipes

☐ Yes

☐ No

If you quit, date:

Cigarette packs per day:  Number of years

Number of cigars per day:  Number of years

Bowls of pipe tobacco per day:  Number of years

How many drinks do you have a day?

beer  wine  liquor

For how long?

Fig. 8



## Family History

Has anybody in your immediate family been diagnosed with the following?

Please list family member:

### Diagnosis

- ☐ Allergies
- ☐ Asthma
- ☐ Diabetes
- ☐ Cancer/Tumor (Type)

- ☐ Thyroid Disease
- ☐ Seizure
- ☐ Eye Problems
- ☐ Genetic Disease
- ☐ Alcoholism
- ☐ Kidney/Bladder Problems
- ☐ Ulcer
- ☐ Arthritis
- ☐ Heart Problems
- ☐ High Blood Pressure

### Family Member



Fig. 9